STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555726	A. Building B. Wing	07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mar Vista Country Villa Healthcare & Wellness	3966 Marcasel Ave Los Angeles, CA 90066

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure one of three sampled residents (Resident 1) was closely supervised, monitored, and within staff reach to prevent a fall. The facility was aware that Resident 1 is confused (is the inability to think as clearly or quickly as you normally do), has a history of falls, and impulsive behavior (refers to actions that are taken without sufficient thought or consideration of the consequences) of getting up from the wheelchair (WC) without assistance.This deficient practice resulted in Resident 1 falling on 6/24/2025 at 8:30 PM. On 6/24/2025 at 8:30 PM, Resident 1 was transferred to a General Acute Care Hospital (GACH) emergency room (the department of a hospital that provides immediate treatment for acute (sudden onset) illnesses and trauma[injury]) for further evaluation via 911 (emergency response telephone number). GACH diagnosed Resident 1 with closed fracture (a break in a bone that does not extend through the skin or surrounding tissues) of the left orbital floor (the bony socket around the eye), and swelling and abrasion (a superficial wound caused by the scraping or rubbing away of skin or other surface tissue) of the left eyebrow. During a review of Resident 1's admission Record indicated the facility admitted Resident 1 was admitted on [DATE] with diagnoses including dementia (a decline in mental ability severe enough to interfere with daily life), muscle wasting/atrophy (when muscles start to shrink and weaken), difficulty in walking, and mixed incontinence (involuntary leakage of urine). During a review of Resident 1's admission Fall Risk Evaluation record dated 5/28/2025, the fall risk evaluation record indicated that Resident 1's fall risk score was 10 (a score of 10 or greater is an indicator that the resident is at a high risk for falls). The fall risk evaluation record indicated that fall prevention protocol (nonspecific) should be initiated immediately and documented on the care plan. During a review of Resident 1's High Risk for Fall care plan (CP) initiated on 5/29/2025, the CP indicated that Resident 1 is a high risk for falls related to the history of fall, confusion, incontinence (the involuntary loss of urine and stool), poor communication/comprehension, psychoactive drug (a drug or substance that causes changes in mood, awareness, thoughts, feelings, or behavior) use and recent hip surgery (not specified). The High Risk for Fall CP indicated Resident 1 has balance problem while standing and while walking, has decreased muscular coordination, and requires use of assisting device (such as cane, wheelchair, walker, and furniture) for mobility. The High Risk for Fall CP goals included to assist Resident 1 with ambulation and transfers, . and evaluate for fall risk on admission and PRN (as necessary). During a review of Resident 1's Care Plan Report on Status Post Fall (S/P) dated initiated 5/29/2025 and revised on 6/25/2025, indicated Resident 1 fell on [DATE]. The Care Plan Report goals indicated that Resident 1 will be free of falls, will be free of minor injury, and will not sustain serious injury through target date of 9/9/2025. The Care Plan Report interventions included facility to follow the fall protocol (unspecified), frequent visual monitoring, and place the resident in front of the nursing for visual monitoring . and prompt availability of staff (initiated on 6/2/2025). The Care Plan Report interventions also included to review information on past falls and attempting to determine cause of falls. During a review of Resident 1's Multidisciplinary Care Conference (MCC-is a mechanism by which information is shared between various professionals involved in the patient's care) dated 5/30/2025, at 11 A. M., the MCC indicated Resident 1 is a high risk for falls. The MCC interventions included to have the resident's bed in a low position, placing bilateral (both side) floor mats, and supervising Resident 1 closely. The MCC indicated that Resident 1 family member (FM) stated Resident 1 has been having anxiety, has poor impulse control, is high risk for falls, and does not call for assistance. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 6/4/2025, it indicated Resident 1 was cognitively impaired (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 1 was dependent on staff assistance with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 1's Situation Background Appearance Review and notify (SBAR - a communication tool used by healthcare workers when there is a change of condition among the residents) dated 6/24/2025 documented by Licensed Vocational Nurse (LVN) 1, the SBAR indicated that on 6/24/2025 at 8:30 P.M. had a witnessed fall and hit her head (Fall witnessed by LVN 1). The SBAR indicated, [Resident 1] stood up from the [WC] attempting to ambulate without assistance. Upon assessment, [Resident 1] alert and responsive. Observed [Resident 1] with left eye swelling and applied ice pack. [Resident 1] able to move all extremities without difficulty. The SBAR indicated that a